CHAPTER 8
SECTION 7

CLAIM DEVELOPMENT

1.0. GENERAL

1.1. The contractor shall use available in-house methods, i.e., contractor files, telephone, DEERS, etc. to obtain missing, incomplete, or discrepant information. If this is unsuccessful, the contractor may return the claim to the sender with a letter stating that the claim is being returned, stating the reason and requesting the missing or required information. The letter shall request all known missing or required documentation. The contractor's system must identify the claim as returned, not denied. The Government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits.

1.2. If a claim is to be returned to a beneficiary who is under 18 years of age and involves venereal disease, drug or alcohol abuse, or abortion, the contractor shall contact the beneficiary to determine how he or she wishes to complete it. See Chapter 8, Section 11, paragraph 1.7.4. regarding possible contact procedures and the need for both sensitivity and use of good judgment in the protection of patient privacy. **Mail development shall not be initiated on this latter type of claim without consent of the beneficiary irrespective of whether it is a network or non-network claim**.

1.3. The request for missing information shall be on the contractor's TRICARE letterhead and provide the following:

- Name of contractor
- Address for return of requested information
- Telephone number of the contractor
- Specific statements clearly identifying all information required
- Timely filing requirements
- Notice that the information must be furnished before the claim can be processed.

2.0. REVIEW REQUIREMENTS

2.1. General

The contractor shall review all claims to ensure required information is provided with each claim prior to payment.

2.2. Form HCFA 1500

Item 13, which authorizes payment to provider, does not apply to TRICARE claims.

2.3. Agreement To Participate

2.3.1. If the provider has agreed to participate, payment to the full extent of program liability will be paid directly to the provider, but the payment to the provider from program and beneficiary sources must not exceed the contractor determined allowable charge except as provided in payments which include other health insurance which is primary. In such a case, the provisions of 32 CFR 199.8; OPM, Chapter 9; and the Policy Manual, Chapter 13, Section 12.1 will apply.

2.3.2. In all cases in which the contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. (See Chapter 9 for cases where double coverage is also involved.) If it comes to the contractor's attention that the terms have been violated, the issue shall be resolved as outlined in Chapter 14, under procedures for handling violation of participation agreements. If the provider returns an adjustment check to the contractor indicating that payment had been made in full, an adjustment check shall be reissued to the beneficiary/sponsor.

2.3.3. If the non-network provider is clearly not participating or the intent cannot be determined, pay the beneficiary (parent/legal guardian).

2.4. Claims For Certain Ancillary Services - Administrative Tolerances For Diagnosis

2.4.1. Provider-submitted claims (participating and non-participating) for inpatient or ambulatory surgery anesthesia, laboratory, and radiology services or outpatient laboratory and radiology services shall not be returned for an incomplete, discrepant or missing diagnosis if the billed amount is $200.00 or less and the claims involve only the specified ancillary services. If the billed amount is greater than $200.00, the contractor shall return the claim requesting the diagnosis. For inpatient or ambulatory surgery services, the diagnosis from the hospital's, ambulatory surgery center's or attending physician's claim for the same inpatient or ambulatory surgery episode shall be used if on file. For outpatient services, the diagnosis from the physician's office services shall be used if on file. Otherwise, code the incomplete, discrepant, or missing diagnosis as 799.9 when the billed amount is $200.00 or less.

2.4.2. The administrative tolerance described above is applicable only to provider-submitted claims for the ancillary services cited. This includes claims submitted by an institution when the claim is for those specific ancillary services; and the services were performed in an institution other than the institution in which the beneficiary is receiving inpatient care or ambulatory surgery care. Provider submitted claims for services other than those cited above, or beneficiary-submitted claims shall be returned for the diagnoses.

2.4.3. Contractors shall conduct an audit review of all ancillary service claims processed with incomplete, discrepant or missing diagnoses and/or beneficiary signature when such claims are in review samples or are "special handling" cases. These cases are claims included in the required one percent internal quality reviews; the claims pulled for TMA claim audit (do not delay the audit sample review after it is sent), and those pulled for adjustment or for informal review. These will be audited by comparing against the institutional claim or related physician claim for the same period. In the event discrepancies are found which indicate fraud or abuse, refer to Chapter 14, Section 3.

2.4.4. If laboratory tests billed by a non-network provider were performed outside the office of the non-network provider, the place where the laboratory tests were performed must be provided. The contractor shall approve arrangements for laboratory work submitted by network physicians. To be covered, the services must have been ordered by an MD or DO and the laboratory must meet the requirements to provide the services as required under the 32 CFR 199, and TMA instructions.

2.5. V Codes

2.5.1. The ICD-9-CM codes listed in the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services, otherwise known as V codes, deal with circumstances other than disease or injury classifiable to the ICD-9-CM categories 001-999. V codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary's encountering the health care system. Claims with V codes as the primary diagnoses are to be processed as follows without development.

2.5.2. V codes which provide descriptive information of the reason for the encounter based on the single code, e.g., V03.X (Prophylactic vaccination and inoculation against bacterial diseases), V20.2 (Routine infant or child health check), V22.X (Supervision of normal pregnancy), V23.X (Supervision of high risk pregnancy) V25.2 (Contraceptive management), are acceptable as primary diagnoses. Claims with these codes may be processed according to TRICARE benefit policy without additional diagnostic information.

2.5.3. V codes for outpatient visits / encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit / encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, a V code for radiologic exam, V72.5, followed by the code for 786.50 (wheezing) or 786.50 (chest pain) is acceptable. If the diagnosis or problem is not submitted with a claim for the V-coded ancillary service and the diagnosis is not on file for the physician's office services, the claim is to be denied for insufficient diagnosis.

2.5.4. V codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to the personal or family history condition. Claims with these codes may be processed according to the TRICARE benefit policy without additional diagnostic information. Specifically, the treatment areas are as follows:

- Diagnostic and Screening Mammography, e.g., V725, V103, V1589 and V163.
- Pap Smears, e.g., V72.3, 76.2, and V15.89.
- Screening for Fecal Occult Blood, e.g., V10.00, V10.05 and V10.06.

2.5.5. Claims with the only diagnoses being V codes which do not fall into one of the above of categories, e.g., codes indicating personal or family histories of conditions, are to be denied for insufficient diagnosis. This includes those V codes corresponding to the V codes for "Conditions not Attributable to a Mental Disorder" in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

2.6. Itemization

2.6.1. Inpatient Institutional Services

All data required for accurate completion of the Health Care Service Record must be provided / obtained whether the provider is network or non-network.

2.6.2. Outpatient Institutional Services

The appropriate "Not Otherwise Classified Code" (NOC) shall be used. The network providers shall comply with the agreements with the contractor.

2.6.3. Individual Provider Services

Claims for individual providers (including claims for ambulatory surgery) usually require materially more detailed itemization than institutional claims. The claim must show the following detail:

- Identification of the provider of care;
- Dates of services;
- Place of service, if not evident from the service description or code, e.g., office, home, hospital, skilled nursing facility, etc.;
- Charge for each service;
- Description of each service and / or a clearly identifiable / acceptable procedure code; and
- The number / frequency of each service.

2.7. Prescription Drugs And Medicine (Insulin)

Contractors shall accept pharmacy receipts (legible photocopies of pharmacy receipts are also acceptable) or prescription listings on pharmacy letterhead, which contain all the information required below.

- The name of the patient.
- The name, strength, and quantity of each drug.
- Prescription number of each drug, except insulin.
- The cost of each drug.
- The date prescription was filled.
- The name of the prescribing physician or physician assistant.
- The name of the pharmacy where the drug was purchased.

NOTE: Prescriptions for controlled substances written by providers who do not have individually assigned DEA numbers, shall not be accepted.

2.7.1. Drug Claim Tolerances

The contractor shall establish drug tolerances for controlled and uncontrolled drugs to guard against abuse.

2.7.2. Drugs Dispensed Under A Manufacturer's Charge Card Program

2.7.2.1. In some instances, only a single manufacturer may produce a certain drug (e.g., Berlex Labs is the sole producer of Betaseron for multiple sclerosis) and may establish a charge card program for the distribution of the drug. In such situations, the patient establishes an arrangement with the manufacturer to pick up the drug at a local pharmacy, but agrees to make payment directly to the manufacturer. The local pharmacy does not collect any money or charge the beneficiary for the drug, since the beneficiary has already paid the manufacturer.

2.7.2.2. In instances such as those described above, the manufacturer will send an invoice-like document (e.g., a "Credit Transaction Record") to the patient, showing the amount the patient has been charged for the drug. However, these documents may contain a disclaimer stating: "This is not an Invoice for Payment" or similar language, along with a "fine-print" explanation of the charge card program. At the same time, the patient's receipt from the dispensing pharmacy will show charges of "zero," leaving the patient without a true bill from the manufacturer or an itemized receipt from the dispensing pharmacy.

2.7.2.3. Where it can be established that a beneficiary has obtained drugs under a manufacturer's charge card program, the claim may be processed for payment when it is accompanied by BOTH:

- The manufacturer's Credit Transaction Record which reflects the actual charges to the patient; and
- A record / receipt from the dispensing pharmacy showing the drug was actually dispensed to the patient.

2.7.2.4. Under the circumstances described above the patient is responsible for payment to the manufacturer; therefore, claims shall be reported as consolidated drug claims, with the provider shown as "Your Pharmacy".

2.8. Program For Persons With Disabilities (PFPWD)

2.8.1. General

PFPWD claims must be submitted on the DD Form 2642, HCFA Form 1500, or the UB-92. Valid PFPWD claims are to be processed the same as basic program benefit claims except that:

2.8.1.1. PFPWD unique cost-share shall be applied using the sponsor's DEERS pay grade in effect at the time the service or item was rendered.

2.8.1.2. The PFPWD has a government cost-share dollar limit which is different from basic program cost-share and is also different for sponsors with one, or more than one, PFPWD dependent.

2.8.2. Multiple Dependents Under PFPWD

If it is suspected that there may be multiple PFPWD-authorized dependents of one sponsor, the contractor shall:

2.8.2.1. Suspend processing PFPWD claims for all PFPWD beneficiaries of the sponsor when the amount for any one beneficiary exceeds the $1,000 maximum benefit for the month; AND

2.8.2.2. Use internal authorization files, the information on the claim(s), or contact the sponsor or guardian to determine whether there was more than one dependent approved for PFPWD benefits during the month(s) covered by the claim(s).

2.8.2.3. When only one dependent was approved during the month(s), deny all allowable charges in excess of the $1,000 benefit limit. The basis for denial shall be that the PFPWD maximum monthly benefit amount has been exceeded.

2.8.2.4. When it is determined that the sponsor has two or more PFPWD-eligible dependents both receiving care in a given month, process to payment any claims for which the allowable charges cumulative amount to less than the $1,000 benefit limit.

2.8.2.5. Suspend any claims, which, if paid, would be in excess of the $1,000 benefit limit and determine whether all claims for all PFPWD approved dependents have been received for the month.

2.8.2.6. At the end of the suspense period each of the sponsor's dependents shall be ranked according to the total amount of PFPWD allowable charges for each month of service in the claim. The $1,000 allowable amount benefit limit shall be waived for each dependent, except the dependent with the least amount of total allowable charges, for a given month.

2.8.2.7. The dependent to whom the $1,000 PFPWD benefit limit is assigned must be redetermined for each month in which any dependent in a sponsor group with multiple PFPWD-approved dependents, has an allowable amount, for the month, which exceeds the $1,000 TRICARE share limit.

EXAMPLE: Sponsor is a W-3, W-4, or an O-4.

PATIENT	ALLOWABLE FOR FEB.	APPLY TOWARD $1,000	SPONSOR PAYS	GOV'T PAYS
Joe	$ 750	$ 750	$ 50 c/s	$ 700
Ed	$ 900	-	-	$ 900
Sue	$ 1,200	-	-	$ 1,200

NOTE: Should the contractor become aware that a PFPWD beneficiary is receiving care in a different contractor region, the contractor shall coordinate and adjust claims accordingly.

2.9. Ambulatory Surgical Centers

Ambulatory surgery centers (either freestanding or hospital-based) may bill both facility charges and professional charges on a HCFA 1500 claim form, and the facility charges are reimbursed based on the procedures performed (by CPT-4 or HCPCS code). Facility charges and professional charges cannot be filed on the same claim, and all claims for ambulatory surgery services billed on a HCFA 1500 must indicate whether the claim is for facility charges or professional charges and the procedure(s) performed.

2.10. Electronic Crossover Claims for Medicare

TRICARE For Life claims for which TRICARE processes after Medicare, do not need to be developed to the individual provider level for home health or group practice claims.